

VULNERABLE POPULATIONS FINDINGS AND RECOMMENDATIONS

I. INTRODUCTION

“As members of human communities, we are all potentially vulnerable”¹

LuAnn Aday

“Better-integrated and better-organized systems of care promise potentially high quality and effective care, but only if a commitment is made at the outset to strong quality assurance, a service ethic that cares for the whole person, and outreach to those in the community who are most in need”²

Joyce Dubow

A. Definition of Vulnerable

Serving the special needs of vulnerable populations creates a unique challenge for managed care organizations, be they health plans³ or provider organizations contracting on a prepaid capitated basis. Managed care does have a great potential for better serving vulnerable beneficiaries by providing more effective management, coordinating multiple medical and social services, and exercising greater flexibility in providing the care that beneficiaries may require.⁴ However, the capacity of a plan to provide appropriate care for persons with chronic or complex illnesses and circumstances depends to a large extent on the way the plan is organized and financed. Appropriate staffing and coordination of services is as critical to quality of care, as is adequate risk adjustment to the financial stability of plans.

Traditionally, society has recognized vulnerable individuals and groups and supported public health and treatment-oriented programs and services to address their needs. The interface of managed care plans with the public health and other safety-net providers for at-risk persons is of major concern for all vulnerable groups. In this paper the Task Force makes both recommendations that apply to all vulnerable populations, and recommendations that are specific to populations that receive care through government's contractual relationships with providers.

As government payors move larger portions of Medicare and Medicaid beneficiaries into managed care, the need to address safeguards for vulnerable populations has come to the collective forefront of federal and state policy-makers' agendas. At stake is the health status of beneficiaries who must rely on regulatory safeguards and governmental oversight to protect their general interest through contractual requirements negotiated with managed care health plans.

The movement of significant beneficiary pools from traditional unmanaged fee-for-service “indemnity” insurance plans to managed care also has an effect on the commercial health plan industry and the provider community. Commercial and public health plans participating in Medi-Cal and Medicare must make significant investments in provider network development, information systems, and clinical quality and utilization management. These demands place at risk an entire safety-net system of care which might not be able to manage the transition cost. At greatest risk is the county health care infrastructure.

¹Aday, L, *At Risk In America: The Health and Health Care needs of Vulnerable Populations in the United States*, 1993.

²Dubow, J, “Medicare Managed Care: Issues for Vulnerable Populations”, Public Policy Institute of the AARP.

³The term “health plans” refers to any health insurance arrangement or health benefits financial intermediary.

⁴Interview Dr. Helen Rodriguez-Trias, Task Force member and Mary Dewane, CEO CalOPTIMA.

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Counties may be unable to compete for members who may, for the first time, be presented with recognizable choices, not just of health plans but of private and public delivery systems.

The true power of the payor to cause the managed health care industry to change has been greatly enhanced by the sheer size of the populations being moved into prepaid health plans. The impact on the behavior of both public and private health systems now thrown into direct competition for health plan membership will be significant.

There are a number of vulnerable populations, some of whom are highlighted in this report. They include the following:

- Frail elderly
- Adults with disabilities
- Children with disabilities
- High risk pregnant women
- Foster children
- Chronically ill, HIV/AIDS
- Socially and economically disadvantaged, culturally isolated
- Suffering mental illness
- Chemically dependent.

These populations present a unique challenge to managed care organizations and, to a great degree, will serve as the public's litmus test as to whether managed care can and will be the principal model of health care delivery beyond the year 2000.

B. Problems of Vulnerable Populations in Managed Care Settings

The results of Miller and Luft's recent study⁵ on managed care versus indemnity performance indicates that health maintenance organizations (HMOs) produce better, the same, and worse quality of care depending on the particular organization and particular disease. However, three of the five observations with significant negative HMO results focus on chronically ill, low-income enrollees in worse health, impaired or frail social HMO (SHMO) demonstration enrollees, and Medicare home health patients, many of whom have chronic conditions and diseases. While it is true that some quality of care results that show better or mixed HMO quality are also at least partially based on data for patients with chronic conditions and diseases, and that there are many valid cautions against over-interpreting the results, the fact that three significantly negative HMO quality of care results were for Medicare HMO enrollees with chronic conditions and diseases raises cause for concern. In addition, based on the interviews with the many advocates and foundations contributing to this report, some managed care arrangements may raise issues with respect to the following challenges that need to be addressed in serving these populations:

- Under-treating patients with chronic illness
- Restrictions in seeking specialists
- Lack of expanded systems of care and limited benefits definition
- Discontinuity of treatment
- Lengthy time frames for authorization

⁵ Miller R and Luft H, "Does Managed Care Lead to Better Or Worse Quality of Care?", *Health Affairs*, September/October 1997.

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- Lack of consumer understanding
- Providers' failure to diagnose accurately.

II. RECOMMENDATIONS

An overarching principle of all the recommendations referring to vulnerable populations is acknowledging that they are the best and most effective advocates and arbiters of their own care. Best practices must be based on their inclusion in decision making, standard setting, and quality improvement.

A. Recommendations from Other Report Sections Particularly Important to Vulnerable Populations

Like all health care consumers, vulnerable populations need appropriate quality care, reliable information, effective systems to resolve disputes and the assurance that there will be effective private and public sector oversight. However, in many cases the issues facing vulnerable populations are more complex and require special attention. Because of this, many of the recommendations made by the Task Force in other sections of this report have special relevance for vulnerable populations. What follow is a reiteration of those recommendations from other sections that have particular importance to vulnerable populations.

- Health plans should be required to establish and implement a procedure by which an enrollee with a condition or disease that requires specialized medical care over a prolonged period of time and is life-threatening, degenerative, or disabling may receive an extended, prolonged, or permanent referral to a specialist. Such referrals should be conducted in a manner that maintains coordination of services (e.g., updating the PCP, sharing of medical records, agreeing on shared treatment plans, and agreeing on the respective roles of each practitioner). [Physician-Patient Relationship recommendation]
- Health plans and medical groups/IPAs should be required to enable consumers who are undergoing a course of treatment for a chronic, acute, or disabling condition (or who are in the second or third trimester of a pregnancy) at the time they involuntarily change health plans or at a time when a provider is terminated by a plan or medical group/IPA for other than cause (at the patient's option) to continue seeing their current providers until the course of treatment (or postpartum care) is completed, up to a maximum of 90 days or until the patient's condition is such that the patient may be safely transitioned to a new provider. [Physician-Patient Relationship recommendation]
- Health plans should be required to ensure that contracting health practitioners who treat commercial patients and who are at substantial financial risk (as currently defined by federal law) obtain stop-loss coverage, maintain sufficient reserves, or have other verifiable mechanisms for protecting against losses due to adverse risk. This provision should be administered in a manner that minimizes the administrative burden on physicians and plans to the extent possible. [Financial Incentives for Providers in Managed Care Plans recommendation]
- Sponsored purchasing groups, such as Pacific Business Group on Health, and accreditation organizations, such as National Committee for Quality Assurance, should review provider incentive compensation arrangements (including non-financial incentives) for the purpose of identifying best practices and practices in need of improvement, and seek to influence plan and provider groups accordingly. Particular attention should be paid to the promotion of risk factor measurement (e.g., morbidity and mortality rates) and risk adjustment and compensation arrangements that continue to include rewards for quality care, consumer satisfaction, and other non-financial factors. [Financial Incentives for Providers in Managed Care Plans recommendation]

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- The state entity for regulation of managed care⁶ should conduct a pilot project with a variety of health plans, their contracting medical groups, other provider groups, and consumer groups to develop clear, simple, and appropriate disclosure language (field-tested for consumer understanding and value) and the most cost-effective methods for distribution to enrollees. The entity should report results back to the Legislature to consider how best to approach provider group disclosure. [Financial Incentives for Providers in Managed Care Plans recommendation]
- California should stimulate action to adopt risk adjustment while maintaining patient confidentiality, where technically feasible. [Minimizing Risk Avoidance Strategies eight recommendations]
- State to create a “blue ribbon” public/private work group of major stakeholders⁷ to study and recommend changing the benefit language in health plan contracts. Benefit definitions should consider the needs of seniors, children, persons with disabilities and other vulnerable populations and should consider the objective of maximizing functional capacity and the inclusion of benefits to maintain function and to slow or prevent deterioration of function. [Improving the Delivery of Care and the Practice of Medicine recommendation]
- Health plans should incorporate provider pre-credentialing and the use of practice guidelines, clinical pathways, retrospective review (as opposed to prior authorization/concurrent review) and outcomes-based data into their established utilization monitoring processes. Processes should be developed based on statistically valid data on patterns of care and patient outcomes, or professional consensus, that are sensitive to the needs of various populations, including vulnerable populations. These data sets or professional consensus may then form the basis on which alternatives to prior authorization can be based. [Improving the Delivery of Care and the Practice of Medicine recommendations]
- The state entity(ies) for regulation of managed care should be authorized and directed to convene a working group to develop a standard outline and definitions of terminology for Evidence of Coverage (EOC) and other documents to facilitate consumer comparison and understanding. The working group should include the major stakeholders. [Standardizing Health Insurance Contracts recommendation]
- The state entity(ies) for regulation of managed care should create and update at least annually a “standard product description” in a format to facilitate direct comparison of plans by consumers, designed with input from stakeholders, in as non-political a process as possible. The DOC should require plans to use the standard format to present information about any product they offer. This standard benefits characteristics document should include a statement on how drug formulary decisions are made; should describe key elements of the plan’s grievance procedure; should include independent “exit polling” information on number disenrolling and primary reasons for disenrollment; and should offer, for each plan or medical group with which the plan contracts, a brief but specific description of the referral and authorization process, and the process through which medical decision are made. [Consumer Information, Communication, and Involvement recommendation summary]
- Health plans must adopt best grievance practices, including having adequate internal systems and information to provide assistance which may be particularly important for vulnerable populations. Two pilot, independent external assistance or ombudsman programs should be authorized, and state funding should be secured. Such pilot programs should be used to assess how best to serve and

⁶ Throughout this paper, the term “state entity for regulation of managed care” refers to DOC or its successor. In its plural form, state entity(ies) refers to DOC, DOI or their successor.

⁷ Throughout this paper, the intention of the Task Force is that stakeholders include consumer groups, including representatives of vulnerable populations, providers, provider groups, health plans, and purchasers.

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educate consumers about external assistance and to complement existing resources. [Improving the Dispute Resolution Process recommendation]

- Plans should establish a governing body which is composed of at least one third member or enrollees and ensure that sufficient resources are made available to educate enrollee board members so that they can participate effectively. This committee(s) shall communicate and advocate for members' needs and serve as a resource for the governing body and HMO/plan administrators. It shall be responsible for establishing mechanisms and procedures for enrollees to express their views and concerns about the HMO/plan, including the viewpoints of enrollees who are members of vulnerable populations. [Consumer Information, Communication & Involvement recommendation]

B. Recommendations that are Specific to Vulnerable Populations

In addition to the recommendations made in other sections of this report, the Task Force makes the following recommendations that it considers critical to better understanding and meeting the needs of vulnerable populations in managed care settings.

1. The Task Force encourages purchasers to explore the feasibility of identifying and tracking the vulnerable populations among their membership, and reporting technologically feasible performance outcomes for these populations. Purchasers should work with DHS to determine how to develop most effectively the systems necessary to implement such identification, tracking, and reporting.
 - (a) Purchasers should explore the feasibility of providing incentives for plans to implement effectively by withholding a percent of the premium and paying plans on a sliding scale based on performance.
 - (b) Purchasers should explore the feasibility of developing common contract standards for plans to track, identify, and monitor performance outcomes for all vulnerable populations.
2. The Task Force encourages continuing DHS and other entities' efforts to study and pilot initiatives to assess the feasibility of the integration of acute, chronic, and long-term care services, as well as linkages to social services in the community for all plans.
3. The Task Force recommends that purchasers encourage those plans they contract with to work towards credentialing and certifying medical groups and providers based on their knowledge, sensitivity, skills, and cultural competence to serve vulnerable populations.

C. Application of Recommendations to the Medi-Cal/Medicare Populations

4. Resources should be provided to DHS to prepare annual reports for the Legislature and interested public on the quality of and access to care for Medi-Cal consumers and include the following topics:
 - (a) A comparison of the performance of plans within each Medi-Cal managed care county as well as among counties
 - (b) A comparison of networks among plans and between private pay and Medi-Cal commercial plans
 - (c) A comparison of access, quality, and cost indicators for Medi-Cal managed care patients with privately insured patients in California

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- (d) An evaluation of Medi-Cal consumers' (1) understanding of (2) use of and (3) access to managed care plans
- (e) An analysis of the effectiveness of translated materials and the ability of plans to serve multi-lingual and multi-cultural consumer
- (f) An analysis of provider continuity including analysis of impact of changes in Medi-Cal eligibility
- (g) An analysis of patterns of default and disenrollment

The Task Force supports DHS' ongoing efforts to assess the impact of Medi-Cal managed care on the public health system.

5. Resources should be provided to DHS to prepare a periodic report for the Legislature and interested public on the impact of Medi-Cal managed care on the capacity of the public health system and other safety-net entities to provide care for uninsured patients. This should include county-by-county analyses of changes in access and quality for uninsured patients as well as analyses of changes in the institutional capacities of safety-net providers.
6. Resources should be provided to DHS to prepare a periodic report for the Legislature and interested public on the impact of Medi-Cal managed care on the capacity of public health entities to continue their work in population health including their capacity to track epidemiological trends and to do population-based health education.